1915i Policy

Care Coordination Service 510-08–

Service Title: Care Coordination Service

Service Definition (Scope)

Care Coordination is a required component of the 1915(i) and assists individuals with gaining access to needed 1915(i) services. The member has a right to choose their care coordination provider. The Care Coordinator ensures that the participant (and parent/guardian as applicable) voice, preferences, and needs are central to the person-centered planning process.

Care Coordinator Role

A. Comprehensive assessment and reassessment activities include:

- completion of assessments as needed;
- collecting, organizing, and interpreting an individual's data and history including the gathering of documentation and information from other sources such as family members, medical providers, social workers, and educators, etc., to form a complete assessment of the individual, initially and ongoing;
- promoting the individual's strengths, preferences, and needs by addressing social determinants of health including five key domains (economic stability, education, health and health care, neighborhood and built environment, and social and community context) and assessing overall safety and risk including suicide risk;
- conducting a crisis assessment and plan, initially and ongoing;
- guiding the family engagement process by exploring and assessing the participant's and, in the case of a minor the family's, strengths, preferences, and needs including overall safety and risk, including suicide risk, initially and ongoing; and
- ongoing verification of Community-Based Settings compliance.

A participant's need for initial and continued services shall be discussed at each 1915(i) person-centered plan of care meeting, and formally evaluated during the WHODAS 2.0 functional needs assessment as part of the initial evaluation and annual reevaluation process. The Care Coordinator must document a need for the service to support a participant's identified goals in the person-centered plan of care and document the participant's progress toward their goals.

B. Development of an individualized person-centered plan of care including the crisis plan component based on the information collected through the assessment. The care coordinator is responsible for the development of the plan of care and for the ongoing monitoring of the provision

of services included in the participant's plan of care. Services must be identified in the plan of care and service authorization obtained.

C. Crisis Plan Development, Implementation, and Monitoring. The Care Coordination Agency has ultimate responsibility for the development, implementation, and monitoring of the crisis plan. The crisis plan is developed by the Care Coordinator in collaboration with the participant and Person-Centered Plan of Care Team within the first week of initial contact with the member.

D. Referral, Collateral Contacts, and Related Activities. This includes scheduling appointments for the individual and connecting the eligible individual with obtaining needed services including:

- activities that help link the individual with health, housing, social, educational, employment, and other programs and services needed to address needs and achieve outcomes in the plan of care;
- systematically engaging culturally relevant community services and supports on behalf of the individual; and
- contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, and providing members of the individual's team with useful feedback.

The Care Coordination Service assists participants in gaining access to needed 1915(i) and other state plan services, as well as medical, social, educational, and other services regardless of the funding source for the services to which access is gained.

E. Monitoring and Follow-Up Activities. Activities and contacts necessary to ensure the person-centered plan is implemented and adequately addresses the eligible individual's needs. These may be with the individual, family members, service providers, or other entities.

F. HCBS Settings Rule Compliance Verification. The Care Coordinator's role includes verification of HCBS Settings Rule compliance.

See 1915(i) HCBS Settings Rule Policy

Service Limits

There is a daily maximum of 8 hours (32 units) for this service and a minimum of one face-to-face contact between the Care Coordinator and participant per quarter is required.

Service authorization requests exceeding the maximum limit which are deemed necessary to prevent the member's imminent institutionalization, hospitalization, or

out of home/out of community placement will be reviewed by the NDDHS. All requests to exceed limits must initiate with the Care Coordinator.

Service Duplication

1915(i) services cannot be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities.

To avoid service duplication with 1915c Waiver services, the Care Coordinator will contact the State Medicaid Office to inquire if the member has any eligibility spans for any of the C Waivers in MMIS. If yes, the Care Coordinator will reach out to the C Waiver authority and do due diligence to ensure the plan of care will not include services the member could receive through the 1915c Waiver.

See Service Duplication and Involvement in Multiple Medicaid Authorities Policy for additional requirements relating to the Care Coordination Service.

Conflict of Interest

See Conflict of Interest Standards Policy applicable to Care Coordination.

Remote Support

Remote support may be utilized for up to 25% of all care coordination services provided in a calendar month.

See 1915(i) Remote Support Service Delivery Policy for requirements.

Provider Qualifications

Provider Type: North Dakota Medicaid enrolled group provider of Care Coordination Services.

Licensing: None

Certification: None

A group provider of this service must meet all of the following:

1. Have a North Dakota Medicaid provider agreement and attest to the following:
    - Individual practitioners meet the required qualifications.
    - Services will be provided within their scope of practice.
    - Individual practitioners will have the required competencies identified in the service scope.

- Agency availability 24 hours a day, 7 days a week to clients in need of emergency care coordination services.
- Agency conducts training in accordance with state policies and procedures.
- Agency adheres to all 1915(i) standards and requirements agency policies and procedures including, but not limited to, participant rights, abuse, neglect, exploitation, use of restraints, and reporting procedures are written and available for NDDHS review upon request.

The individual practitioner (care coordinator) providing the service must:

1. Be employed by an enrolled ND Medicaid provider or enrolled billing group of this service; and
2. Have a bachelor's degree in social work, psychology, nursing, sociology, counseling, human development, special education, child development and family science, human resource management (human service track), criminal justice, occupational therapy, communication science/disorders or vocational rehabilitation; or have 5 years of supervised, clinical experience working with individuals with SMI, SED, SUD, brain injuries, etc.; or, with accompanying transcript, the NDDHS of Human Services may approve other degrees in a closely related field at the NDDHS's discretion; and
3. Be supervised by an individual containing these qualifications at a minimum.

Agencies must have records available for NDDHS review documenting that care coordinators have reviewed the competencies or standards of practice in one of the following:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) Core Competencies for Integrated Behavioral Health and Primary Care; or
- The Case Management Society of America standards of practice.

Verification of Provider Qualifications

Provider Type: ND Medicaid enrolled agency provider of Care Coordination Services

Entity Responsible for Verification: Medical Services Provider Enrollment

Frequency of Verification: Provider will complete an "Attestation" as part of the provider agreement process upon enrollment and at revalidation. Providers are required to revalidate their enrollments at least once every five (5) years.

Service Delivery Method: Provider Managed

Payment Rate

Care Coordination is a 15-minute rate. The rates will be published at the State's website.

http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-fee-schedules.html

Care Coordination Process

1. The eligible 1915(i) member contacts the care coordinator of their choice to schedule an initial meeting.

2. The initial meeting is held.

   A release of information is obtained to allow the care coordinator to request the diagnosis and WHODAS scores from the Zone 1915(i) Eligibility Worker.

   The Care Coordinator informs the participant and legal guardian if applicable of their responsibility for involvement in the development of the Plan of Care, and their right to choose who they want involved in the plan development.

   Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process.

   The participant and their guardian, if applicable, are given the opportunity to choose the times and location of meeting and the makeup of team membership.

   The participant receives a brochure that explains each of the services and a Rights and Responsibility brochure.

   The initial person-centered plan of care meeting is scheduled, and the care coordinator forwards invites to those the individual has requested be involved.

3. The initial POC meeting is held. *See 1915i Plan of Care Policy for a detailed list of all plan of care requirements.*

   The care coordinator must complete the plan of care within the required 10 business days from initial contact by the member.

   The care coordinator provides the member with a list of service providers for those services the member needs, and the member chooses each service provider.

4. The care coordinator completes a Request for Service Provider form and sends to each provider identified on the POC.

5. Each provider has two business days to confirm or deny the request and inform the care coordinator of their decision.

6. The care coordinator verifies HCBS Settings Rule compliance for each provider setting the member will receive services in. *See 1915(i) HCBS Settings Rule Policy for instructions.*

7. Care coordinator submits the plan of care and their service authorization request for the care coordination service via MMIS to the State Medicaid Agency (SMA) for Traditional Medicaid members and to the MCO for Expansion members. *See 1915(i) Service Authorizations Policy for details.*

8. The SMA or MCO approves the POC, authorizes the service, and MMIS or the MCO informs the care coordinator.

9. Care coordinator forwards the approved plan of care to all identified service providers.

10. Each service provider submits a service authorization request to the SMA (Traditional) and MCO (Expansion).

11. SMA and MCO compare the service authorization request to the plan of care and approves if it matches.

12. Service providers receive approval from either the SMA or the MCO and services begin.

13. Providers verify Medicaid and 1915(i) eligibility via AVRS or MCO prior to each service delivery and services are delivered.

14. All 1915(i) providers document service delivery. *See 1915(i) Medical Records Policy.*

15. Providers submit claims via MMIS to the SMA for Traditional Clients and to the MCO for Expansion clients. *See 1915(i) Billing and Claims Policy*

16. Monthly monitoring of services is required. This is accomplished by the care coordinator collecting written monthly progress reports for each service provider.

17. The care coordinator meets face-to-face with the member at least quarterly to review and update the plan of care as needed., and monthly monitoring of the member and plan is required.

Quality Assurance

The Care Coordination Service providers are required to use the POC checklist to self-monitor their work by completing reviews of their plans and files. A Reporting Template for the Care Coordination provider to report their findings following their reviews is also available on the 1915(i) website. This "self-monitoring" component

completed by the provider will be in addition to the quality assurance reviews of plans of care completed by the NDDHS Behavioral Health Division and the MCO. *See 1915(i) Quality Assurance Policy for specifics.*

Medical Records Requirements including Documentation Requirements, Signatures, Confidentiality, and Availability of Records

See 1915(i) Medical Records Policy.

Person Centered Service Delivery

Care Coordination Services must be Person-Centered.

Care Coordination Providers must also have records available for NDDHS review as verification that care coordinators have reviewed NDDHS approved training materials and acknowledge they are competent in the following areas:

- Person-Centered Plan Development and Implementation

See 1915(i) Person- Centered Care Policy

Person-Centered Plan of Care

See 1915(i) Plan of Care Policy.

HCBS Settings Rule Compliance Verification

See 1915(i) HCBS Settings Rule Policy.

Contact the Managed Care Organization for policy relating to 1915(i) Expansion members.